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When no news is bad news: communication failures and the hidden assumptions that threaten safety

Short title: When no news is bad news

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Communication failures in healthcare can be catastrophic. Lost test results, delayed diagnoses, missing handover information: all can have serious impacts on the safety of care with tragic consequences for patients. Even seemingly trivial mishaps can result in disaster. For example, a young mother died after two referral letters were inadvertently addressed to number 16, rather than number 1b, on the road where she lived, meaning diagnosis and treatment of cancer was significantly delayed. Her 10 year survival at the initial point of referral was estimated as 92%.⁽¹⁾ In another case, a patient died of a major haemorrhage during surgery after pre-prepared, cross-matched blood had been incorrectly sent back to the blood bank due a single character in the patient's name being misspelled.⁽²⁾ These cases, and many others, point to one of the most insidious risks associated with communication in healthcare: many communicative processes are still commonly viewed as rather mundane administrative tasks—instead of safety-critical processes that are essential to safe care.

The lack of attention that is paid to the reliability of some communication processes has recently been revealed on a dramatic scale, with the publication of

an investigation into the major failures affecting the handling of clinical correspondence in the NHS.(3) A backlog of 709,000 items were found to have accumulated over several years in storage rooms and archives operated by NHS Shared Business Services (SBS), and to date almost 1,800 patients have been identified who may have suffered potential harm. Across healthcare, a variety of sophisticated work is being done to understand and improve the reliability of many communication systems(4)—such as the handling of test results,(5,6) the transfer of clinical information(7,8) and patient handover processes.(9) But this massive communication breakdown in the handling of clinical correspondence, along with many other events, points to something fundamental that needs addressing right across our healthcare systems: the hidden assumptions that people hold about what constitutes a reliable communicative process and what safe communication looks like. These assumptions influence both the behaviour of health professionals and the design and implementation of communication processes, and can lie at the heart of why communication systems so often break down.

Assuming the worst or hoping for the best?

Much of the communication that occurs in healthcare is safety-critical—from patient handover to arranging referrals to delivering test results. Increasingly, information systems are being designed to take account of that. However, the reliability of communicative systems and practices are heavily shaped by the

fundamental assumptions of the people who are doing the communicating.(10,11) These assumptions can influence the most basic aspects of communication, such as what is viewed as an acceptable communicative practice, when and if confirmatory messages are sought or expected, and which information is considered critical and which is not. How these assumptions can shape the safety of communication systems is perhaps well illustrated by a personal story.

Not long ago I had a couple of very minor surgical procedures. From start to finish I encountered dedicated, skilled and caring people doing their best for patients. And yet one small moment shocked me—a moment with deep implications for how we organise and think about our most basic systems of communication. My operations were small and routine—the excision of an abnormal mole, then a much larger excision following the lab results. After the first excision I was told with a cheery smile, “We’ll send that off to be tested. If you don’t hear from us then everything’s fine.” To someone who has been fortunate to research, work in and generally hang around safety-critical organisations for the past 15 years, this was immediately alarming.

One of the most basic assumptions of any high-reliability practice is that no news is most certainly not good news.(12) Hearing nothing does not mean that nothing is wrong. Yet here the default assumption was the opposite: no news was good news. If I didn’t hear anything about my test results, then I should assume things are fine. Either that, I thought, or the specimen had been misla-

belled. Or the lab didn't receive it. Or the results were lost in transit. Or my contact details had gone astray. Or any one of the countless other failures that can beset even the most trivial of communicative processes had come to pass.

Where safety is concerned, no news is not good. As a commercial-pilot-turned-air-accident-investigator told me bluntly years ago: "no news means your radio has probably failed." In a safety-critical process—such as the handling of important test results—the absence of a confirmation message should be perceived as a warning: a sign that the communicative system itself has broken down.

Disasters at sea and in the sorting office

The default assumption that no news is not good news is the bedrock of many safety-critical industries. It has been learnt time and again through tragedy.

This year marks the thirtieth anniversary of the Herald of Free Enterprise ferry disaster. On 6th March 1987, the ferry capsized outside the Belgian port of Zeebrugge. The bow doors had been left open allowing water to flood in, tipping the ship in a mere 90 seconds. The assumption on the bridge was 'no news is good news'. Unless they were told otherwise, they assumed the bow doors had been shut and it was safe to set sail. But the doors were not shut and that assumption, combined with a range of other factors, cost 193 people their lives.⁽¹³⁾ By coincidence, the thirtieth anniversary of the Herald of Free Enterprise disaster came only a few days after the systemic breakdown in NHS clinical correspondence handling was made public.⁽¹⁴⁾ Subsequent investigation by the National Audit

Office revealed that 709,000 items of clinical correspondence failed to be delivered between 2011 and 2016 and accumulated in storage rooms.(3) This correspondence included test results, clinical notes and child protection conference notes. Ongoing reviews suggest that, as of 31 May 2017, around 1,788 patients may have suffered potential harm as a result. This number is expected to rise as 175,000 items are still to be reviewed.

These failures in the handling of clinical correspondence represent a deep and systemic communicative breakdown on a remarkable scale. A set of unfortunate assumptions appear to have played a role in shaping the systems and practices that caused this breakdown, in three particular ways.(3) First, one reason the backlog of misdirected correspondence grew so large was because there were no performance indicators associated with addressing it. Staff therefore assumed that clearing the backlog of failed deliveries was of lower priority than other routine sorting and delivery work, and paid it little attention. Second, the main problems posed by the accumulating backlog of correspondence appear to have been assumed to be largely administrative and financial. The patient safety impact of the backlog, and the clinical risks to patients, were not formally recognised by NHS SBS until a report in November 2015. That led to an examination of some of the correspondence and a belated realisation of the severity of the situation in March 2016, five years after the problems began. Third, the scale of the backlog was only recognised after a slow process of internal inquiry at NHS SBS—including a director overhearing a conversation by chance. It appears that the loss of almost three quarters of a million items of clinical correspondence was not a strong enough signal of failure to be detected by those relying on these

communication channels, or to challenge their assumptions about the reliability of this communication system.

No news is bad news

The assumption that no news is bad news—and that communication processes are fragile, prone to failure and need strong systems of internal checks and balances—have been essential features of safety-critical industries for decades. So why are these assumptions not yet systematically embedded in all areas of healthcare? An easy answer might simply be that healthcare systems are often under considerable financial pressure, and are forced to make necessary and hard-nosed trade-offs between efficiency and safety. The long-term value of many reliability-enhancing practices is not always easy to see, while the short-term costs are often highly visible—in the form of duplicate checks, additional confirmation messages, closed loop communication channels, or redundant backup systems. But there also seems to be something more fundamental at work. Rather than making a conscious trade-off between safety and efficiency, it seems many of the risks associated with failures of communication are not widely appreciated in the first place. Assumptions that 'no news is good news' can hide the problem itself. The recent large-scale failure of NHS clinical correspondence handling should be a wake-up call—and one in which we must still hope that dead letters have not led to dead patients. Ultimately, safe systems of communication are built on the deep assumptions and default positions that

collectively shape practice. These assumptions determine what is paid attention to, what is valued, what is ignored, and how systems are designed and implemented. And ‘no news is good news’ might seem a perfectly reasonable and straightforward assumption—until your ship suddenly capsizes.

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